

EXHIBIT 8

U.S. Department of Health and Human Services
Health Care Financing Administration

Form HCFA-R245C Approved 6/99
OMB NOs. 0938-0760 and 0938-0761

Outcome and Assessment Information Set (OASIS-B1)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control numbers for this information collection are 0938-0760 and 0938-0761. The time required to complete this information collection is estimated to average 29 minutes per response including the time to review instructions, search existing data resources, gather the data needed, and complete, review and report the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, Baltimore, Maryland 21244-1850, Mail Stop N2-14-26 and to the Office and Management and Budget, Washington, D.C. 20503.

TRANSFER VERSION (used for Transfer to an Inpatient Facility)

Items to be Used at This Time Point

M0010-M0100, M0830-M0855, M0890-M0906

CLINICAL RECORD ITEMS

(M0010) Agency Medicare Provider Number: _____

(M0012) Agency Medicaid Provider Number: _____

Branch Identification (Optional, for Agency Use)

(M0014) Branch State: ____

(M0016) Branch ID Number: _____
(Agency-assigned)

(M0020) Patient ID Number: _____

(M0030) Start of Care Date: ____/____/____
month day year

(M0032) Resumption of Care Date: ____/____/____ ☐ NA – Not Applicable
month day year

(M0040) Patient Name:

(First) (MI) (Last) (Suffix)

(M0050) Patient State of Residence: ____

(M0060) Patient Zip Code: _____

(M0063) Medicare Number: _____ ☐ NA – No Medicare
(including suffix)

(M0064) Social Security Number: ____ - ____ - ____ ☐ UK – Unknown or Not Available

(M0065) Medicaid Number: _____ ☐ NA – No Medicaid

(M0066) Birth Date: ____/____/____
month day year

(M0069) Gender:

- ☐ 1 - Male
☐ 2 - Female

(M0080) Discipline of Person Completing Assessment:

[illegible]

(M0100) This Assessment is Currently Being Completed for the Following Reason:

- ☐ 1 – Start of care—further visits planned
- ☐ 2 – Start of care—no further visits planned
- ☐ 3 – Resumption of care (after inpatient stay)

☐ 4 – Recertification (follow-up) reassessment [Go to *M0150*]

☐ 5 – Other follow-up [Go to *M0150*]

☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to *M0830*]

☐ 7 – Transferred to an inpatient facility—patient discharged from agency [Go to *M0830*]

- ☐ 8 – Death at home [Go to *M0906*]
- ☐ 9 – Discharge from agency [Go to *M0150*]
- ☐ 10 – Discharge from agency—no visits completed after start/resumption of care assessment [Go to *M0906*]

(M0830) Emergent Care: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**

- ☐ 0 - No emergent care services [If no emergent care, go to M0855]
- ☐ 1 - Hospital emergency room (includes 23-hour holding)
- ☐ 2 - Doctor's office emergency visit/house call
- ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
- ☐ UK - Unknown [If UK, go to M0855]

(M0840) Emergent Care Reason: For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Nausea, dehydration, malnutrition, constipation, impaction
- ☐ 3 - Injury caused by fall or accident at home
- ☐ 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
- ☐ 5 - Wound infection, deteriorating wound status, new lesion/ulcer
- ☐ 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
- ☐ 7 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 8 - GI bleeding, obstruction
- ☐ 9 - Other than above reasons
- ☐ UK - Reason unknown

(M0855) To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital [**Go to M0890**]
- ☐ 2 - Rehabilitation facility [**Go to M0903**]
- ☐ 3 - Nursing home [**Go to M0900**]
- ☐ 4 - Hospice [**Go to M0903**]

INPATIENT FACILITY ADMISSION

(M0890) If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?

- ☐ 1 - Hospitalization for emergent (unscheduled) care
- ☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
- ☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
- ☐ UK - Unknown

(M0895) Reason for Hospitalization: (Mark all that apply.)

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall or accident at home
- ☐ 3 - Respiratory problems (SOB, infection, obstruction)
- ☐ 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
- ☐ 5 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 6 - GI bleeding, obstruction
- ☐ 7 - Exacerbation of CHF, fluid overload, heart failure
- ☐ 8 - Myocardial infarction, stroke
- ☐ 9 - Chemotherapy
- ☐ 10 - Scheduled surgical procedure
- ☐ 11 - Urinary tract infection
- ☐ 12 - IV catheter-related infection
- ☐ 13 - Deep vein thrombosis, pulmonary embolus
- ☐ 14 - Uncontrolled pain
- ☐ 15 - Psychotic episode
- ☐ 16 - Other than above reasons

Go to M0903

(M0900) For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

- ☐ 1 - Therapy services
- ☐ 2 - Respite care
- ☐ 3 - Hospice care
- ☐ 4 - Permanent placement
- ☐ 5 - Unsafe for care at home
- ☐ 6 - Other
- ☐ UK - Unknown

(M0903) Date of Last (Most Recent) Home Visit:

___/___/___
month day year

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

__ __ / __ __ / __ __ __ __
month day year